MCAP Authorized Representative Standard Agreement

Authorized Representative Name: _____

Organization Name: _____

Address: _____

Phone Number: _____

To serve as an authorized representative, a provider, staff member, or volunteer for an organization must sign below. A signed Authorized Representative Standard Agreement must be filed with the Medi-Cal Access Program (MCAP). This agreement is valid for one year from the date that it is signed by the individual.

Check all that apply:

[ ] I acknowledge that I am acting as an authorized representative on behalf of the above-named organization that has been designated the beneficiary's/applicant's authorized representative and not in my individual capacity.

[ ] I acknowledge that the above named organization is a health care provider or facility.

[ ] I affirm that any applicant/beneficiary has already been or shall be advised, prior to appointing the above-named organization, that the above named organization is a health care provider or facility and of all potential conflicts of interest that may exist because of that fact.

By signing below, I hereby accept appointment as an authorized representative and understand and agree that:

- The applicant/beneficiary may revoke this authorization at any time and appoint another individual or organization to act as his or her authorized representative.
- I have no power to act on behalf of the applicant/beneficiary, except as stated in his or her Authorized Representative Appointment Form.
- This Authorized Representative Standard Agreement may not be transferred or reassigned to any other individual.

- Appointment of an authorized representative may not be transferred or reassigned to another individual or organization without a new Authorized Representative Appointment Form being completed and signed by the applicant/beneficiary.

By signing below, I certify that:

- I am not disqualified from acting as the applicant's authorized representative.
- I shall abide by all state and federal laws governing authorized representatives, including, but not limited to, those relating to confidentiality of information, prohibitions against reassignment of provider claims, and conflicts of interest.

By signing below, I certify under penalty of perjury, under the laws of the State of California that the foregoing is true and correct.

Authorized Representative Signature:_____ Date:_____